Maryland Department of Health and Mental Hygiene
AIDS Administration

Testimony Submitted by

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For the hearing "The Domestic Epidemic is Worse than We Thought: A Wake-Up Call for HIV Prevention"

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As the Director of the Maryland AIDS Administration and the incoming Chair of the National Alliance of State and Territorial AIDS Directors (NASTAD), I respectfully submit testimony for the record regarding the current efforts and future direction of HIV prevention programs in the United States. State AIDS directors appreciate the longstanding support of the House of Representatives for domestic prevention programs and the Ryan White Program that are of the utmost importance to Americans living with and at risk for HIV/AIDS. The Committee should also be commended for holding a hearing focusing on domestic HIV prevention activities in light of the Centers for Disease Control and Prevention's (CDC) recent release of new HIV incidence estimates in the U.S. and the alarming rates of infection among gay and bisexual men of all races and African Americans.

In this testimony, I will share with you some of the views of state AIDS directors, in addition to those of the state of Maryland. I have the privilege of having administered state public health HIV programs for both a high prevalence state – Maryland – and a low prevalence state – New Hampshire. My testimony will focus on what state AIDS directors believe will be effective in stemming the tide of new infections, including one of the most neglected and least recognized pieces of the prevention portfolio – HIV/AIDS surveillance. Simply put, we have effective strategies and interventions to significantly reduce new infections. We need sound public health policy to eliminate barriers to the implementation of evidence based interventions and increased resources to expand the reach of our efforts to all those in need.

The mission of the Maryland AIDS Administration is to reduce HIV transmission in our state and to help Marylanders with HIV live longer and healthier lives. The Maryland AIDS Administration administers Maryland's HIV/AIDS prevention, surveillance, and care programs, which are funded by federal and state funds. The Maryland AIDS Administration has been monitoring new reports of HIV infections throughout the state for over 14 years and new reports of AIDS cases since the first case in 1981; Maryland reported the second and third AIDS case in the national AIDS epidemic. We have developed a detailed understanding of the HIV and AIDS epidemics in our state.

As of December 2006, there were over 33,000 people living with HIV/AIDS in Maryland. According to the 2006 CDC AIDS Case Report ranking by rate, Maryland is third in the country (28.5 per 100,000 population) behind the District of Columbia and the U.S. Virgin Islands and the Baltimore-Towson Metropolitan Area is second in the county (37.7 per 100,000 population).

The Maryland AIDS Administration's epidemiological data on HIV cases diagnosed and reported in 2006 indicate that of the approximately 2,144 newly reported HIV cases, over 90 percent are among residents of the Baltimore and Washington metropolitan areas. Forty-eight percent are from Baltimore City followed by Prince Georges County (16 percent) and Montgomery County (11 Percent) In Maryland, HIV disproportionately affects African-Americans (75 percent) men (64 percent), and persons age 30-49 (58 percent). Among Maryland's over 33,000 living HIV/AIDS cases, 80% percent are African-American. The most common exposure category among the newly reported HIV infections was heterosexual contact (49 percent); HIV transmission through heterosexual sex is currently the largest percentage of Maryland's HIV/AIDS epidemic. There has also been an increase in newly reported HIV infections among men who have sex with men (24 percent) in recent years. In 1994, Maryland's

HIV epidemic was largely transmitted through injection drug use (IDU) (60 percent) but now IDU transmission only accounts for 22 percent of the risk behavior for Maryland's HIV/AIDS epidemic. This is a notable public health success.

An important 2004 –2005 supplemental HIV behavioral surveillance study, BESURE, showed that of over 1,000 Baltimore metropolitan area gay men and other MSM recruited from bars, restaurants, social groups, and street locations, one-third were HIV+ (52 percent were African-American gay men and other MSM) and two-thirds of the HIV positive men were unaware of their HIV positive status. African-Americans and young men (18-29) were more likely to be unaware they were positive.

While CDC's new HIV incidence estimates are very valuable in understanding the national HIV epidemic and reflect the urgent need to expand access to HIV prevention initiatives, it is important to remember that each state's HIV/AIDS epidemic – like the Maryland epidemic – differs from the national trends. These differences highlight why it is very important to use available local surveillance data for making local policy and program decisions related to planning and allocation of funds, as well as evaluating the impact of prevention programs.

Role of Public Health in HIV/AIDS

State public health agencies serve an essential and unique role in the delivery of HIV/AIDS prevention and care and treatment programs. The agencies are entrusted through U.S. law as the "central authorities of the nation's public health system" and as such, bear the primary public sector responsibility for health. State public health responsibilities include disease surveillance; epidemiology and prevention; provisions of primary health care services for the uninsured and indigent; and overall planning, coordination, administration, and fiscal management of public health services.

Importance of State Public Health HIV Prevention Programs

HIV prevention and surveillance programs are funded by the CDC under general authority provided by federal public health law. Since 1988, CDC has provided HIV prevention resources to 65 state, local, and territorial health departments to implement comprehensive HIV prevention programs. In FY2008, these health departments received approximately $340 million to conduct the following required components in our comprehensive HIV prevention programs:

- *HIV Counseling, Testing and Referral and Partner Services* aim to ensure that individuals and their partners learn their HIV serostatus, receive counseling on behavior change to avoid infection or prevent transmission, and obtain referrals for prevention and care and treatment services.
- *Health Education/Risk Reduction* provides support for, and technical assistance on, targeted education and outreach activities for individual, group, and community-level interventions and street and community outreach. Health Education/Risk Reduction serves both HIV-negative and HIV-positive individuals.
- *Community Planning* ensures the participation of at-risk, infected and affected communities in the development of effective and appropriate HIV education and prevention programs.
- *Capacity Building* strengthens the delivery of effective prevention programs.

- *Quality Assurance and Program Evaluation* monitors progress, outcomes and the impact of the programs they support, as well as assesses needs and develops culturally appropriate services.
- *Other HIV Prevention Efforts* include HIV/AIDS surveillance, prevention of mother-to-child transmission, STD and viral hepatitis prevention, support for coordination and collaboration and support for HIV laboratories.

In addition to the services required by CDC, state and local HIV/AIDS programs may also support, directly and indirectly, a cadre of other services that work to prevent the transmission of HIV. These include needle and syringe access programs, drug substitution programs and non-occupational post-exposure prophylaxis. HIV/AIDS programs also partner with other public health and community programs including STD prevention, TB prevention, and viral hepatitis and control, substance abuse and mental health, reproductive / maternal and child health, immunization, corrections and education agencies and private clinicians.

Scaling up HIV Prevention

State and local health department HIV/AIDS programs are committed to ending the HIV/AIDS epidemic in our nation.

AIDS directors articulated their vision for America's prevention response by developing, *A New Blueprint for the Nation: Ending the Epidemic Through the Power of Prevention,* and a companion policy agenda. To be successful in reducing the number of new HIV infections, the following action steps must be taken.

Significantly Increase Resources for HIV Prevention

The U.S. must double CDC's domestic HIV prevention budget. We know that HIV prevention in this country works as it has held steady the number of new infections for over a decade. However, all components of our prevention arsenal have been drastically underfunded. As stewards of more than half of the CDC's $692 million domestic HIV prevention and surveillance program budget, as well as significant state resources, HIV/AIDS directors are responsible for implementing comprehensive HIV/AIDS prevention and care and treatment strategies across the nation. Over the past six years, CDC funding to state and local health departments has decreased by $30 million. When adjusted for inflation, experts estimate the CDC's domestic HIV prevention budget decreased over 19 percent between FY2002 and FY2007.

Essentially, states' HIV/AIDS programs are being asked to do more with less funding. For many states, especially medium and low prevalence states, this decline in federal funding over the past five years has resulted in reductions in core components of prevention services such as health education/risk reduction, quality assurance and evaluation, and capacity building. There has also been an increased focus on HIV testing which often forces states to redirect funding or attention away from the more intensive and comprehensive behavioral interventions that are needed to prevent HIV transmission. These funding reductions are occurring while the number of individuals living with HIV/AIDS increases.

Further, there have been several unfunded mandates by CDC in recent years that have diverted resources from direct prevention interventions. A primary example is CDC's requirement that states provide information for the Program Evaluation and Monitoring System (PEMS). While

health departments fully support accountability through the evaluation and monitoring of HIV prevention programs, implementation time spent on PEMS has never been funded. As a consequence of funding cuts and unfunded mandates such as PEMS, states are forced to make difficult decisions that lead to less funding for direct HIV prevention interventions. For example, Florida recently completed a competitive process for community-based organizations to apply for the state's CDC prevention dollars. Out of the 99 applications received, Florida was only able to fund 25 of these organizations to implement HIV prevention programs.

A central activity of state prevention programs is monitoring the epidemic. HIV/AIDS epidemiology, surveillance and seroprevalence activities provide data that are critical to targeting the delivery of HIV prevention and care and treatment services. State health agencies are uniquely positioned to conduct these activities because of the expertise, statutory authority, and confidentiality protections of existing public health disease surveillance and reporting systems. States conduct a variety of surveillance activities to track the HIV/AIDS epidemic. The six main types of surveillance are the following.

- *Core Surveillance* is the primary source of population-based data on persons living with HIV and AIDS in the U.S.
- *Incidence Surveillance* provides reliable and scientifically valid estimates of the number of newly-acquired HIV infections though collection and testing of blood specimens from all newly reported HIV infections; calculation of population-based estimates for HIV incidence; and monitoring and tracking HIV strains for resistance to antiretroviral drugs.
- *Behavioral Surveillance* is a multi-year, CDC sponsored surveillance effort whose goal is to measure an extensive set of HIV risk behaviors and related risk factors among selected high-risk populations in 26 cities with the highest number of people living with HIV/AIDS (as of the end of 2000).
- *Variant, Atypical and Resistant HIV Surveillance* is a CDC-sponsored surveillance project that tests for HIV drug-resistance through genotype testing and measures the prevalence of different strains of HIV.
- *Morbidity Monitoring Project* is a surveillance system under development that will be nationally representative of HIV-infected persons receiving medical care in the U.S. The system utilizes HIV care providers to collect necessary data.
- *Enhanced Perinatal Surveillance* monitors progress made in reducing perinatal HIV transmission.

Federal funding has eroded over the last decade for core HIV/AIDS surveillance. These data are critical in understanding the local HIV/AIDS epidemic; targeting the delivery of HIV prevention and care, and treatment services and distributing resources for HIV/AIDS care and treatment via the Ryan White Program. CDC has been unable to sustain adequate funding for special surveillance projects such as incidence surveillance (new infections) which led to the new HIV estimates released in August of this year. For example, Maryland's total budget for HIV/AIDS Surveillance was reduced by 40 percent in the last year and the state is no longer funded for Incidence Surveillance or Variant, Atypical, and Resistant HIV Surveillance projects. In every state implementing these projects, the projects were integrated with core surveillance and therefore, the loss of funds jeopardizes not only important projects such as Incidence Surveillance, but also core surveillance activities. Further, the loss of funding for surveillance results in a loss of capacity to describe the HIV epidemic in jurisdictions this impacts both HIV

prevention program planning and Ryan White and CDC funding. The CDC needs additional funding to restore incidence surveillance in the eight jurisdictions, including Maryland, which recently lost their grant awards and to shore up core surveillance across all jurisdictions.

Replicate HIV Prevention Successes

Many states have had significant public health successes in reducing HIV transmission from injection drug use (IDU) and from perinatal exposures. These successes demonstrate that HIV prevention works and that the combined efforts of the state health departments, local health departments, health care providers, consumers, community-based organizations, private industry, media leaders, and institutions of faith make a difference in the HIV epidemic in our states.

Of greatest importance, prevention tools that directly prevent HIV infection must be made readily available: condoms, clean needles and syringes, treatment for sexually transmitted diseases (STDs), and efforts to prevent mother-to-child transmission. Prevention strategies such as HIV counseling and testing; partner services; behavioral interventions, including individual counseling and small group, community-level and peer-opinion leader interventions; treatment adherence; public information campaigns; and comprehensive sexuality education are all successful in stopping the spread of HIV/AIDS. The expansion of HIV testing efforts is an important component of the comprehensive HIV prevention portfolio, but testing efforts must be balanced with other strategies and interventions that prevent infections before they occur. To this end, all tools in the prevention arsenal must be adequately supported and replicated to scale.

NASTAD supports Representative Jose Serrano's legislation, "The Community HIV/AIDS and Hepatitis Prevention Act of 2008" (HR 6680), which would effectively end the ban on use of federal funds for syringe access programs. This would have a significant impact on states by allowing them to use federal funds to support syringe access programs and reduce new infections in a very highly impacted population.

Expand the HIV Prevention Arsenal

Research translated into practice is essential to ending this epidemic. New behavioral interventions must be developed and interventions that are shown to be effective must be made widely available as quickly as possible. The new behavioral interventions must be developed to meet the needs of specific high risk populations. These interventions must be pulled from all sources, including rigorous academic research as well as locally-developed empirical studies. Those currently in the clearance pipeline must be fast-tracked to offer alternatives to our programs in the short-term as other interventions are developed.

CDC's Compendium of Evidence-Based Interventions includes rigorously researched and tested interventions that are available to prevention providers as tools proven to reduce behaviors that can lead to HIV infection. Due to a lack of funding for behavioral research at the National Institutes of Health (NIH) and CDC, interventions that support positive behavior change are not available for all high-risk populations. There is currently only one CDC approved prevention intervention for black gay and bisexual men and no specific interventions for Latino gay and bisexual men. There are also no interventions targeting transgender individuals, sex workers or homeless persons.

Due to a lack of approved CDC interventions, states develop interventions that are responsive to the local epidemic and prevention needs. For example, Maryland designed and launched two interventions: 1) the *Pharaoh* intervention for African American men with a history of incarceration which helps men explore the connection between gender stereotypes and their own behavior and 2) the *RISE—Rewriting Inner Scripts*—intervention for same-gender-loving African-American men which helps men explore and address oppressions that impact behaviors and connects the men into other health services such as HIV testing, HIV treatment, and substance abuse treatment. These efforts are critical to addressing our local epidemics; however, they are unfunded and take resources.

We must also invest in strategies deemed effective but not widely practiced such as non-occupational post-exposure prophylaxis. And, despite controversy and set-backs, further research into the development of options such as microbicides, vaccines and pre-exposure prophylaxis using antiretroviral drugs, must be scaled up.

Encourage all People Living with HIV/AIDS to Know their Status

We must continue to expand both targeted HIV counseling and testing and referral routine HIV screening efforts. Each of our jurisdictions must consider the cost effectiveness and efficacy of testing approaches and be allowed the flexibility to plan testing efforts appropriately. The Maryland Counseling, Testing and Referral (CTR) Services program provided 61,892 HIV tests to the residents of Maryland in 2007. Of these tests, the number of newly identified, confirmed HIV positive clients was over 1 percent. The majority of the clients tested were African Americans between the ages of 20 and 39.

The CDC initiative, *Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV, Primarily African Americans* (PS07768), is an important step to increasing knowledge of serostatus. Currently 23 jurisdictions (18 states and five cities) receive funds for testing, including rapid testing, in clinical settings such as emergency rooms, community health centers, and STD and tuberculosis clinics. The funds can also be used to support partner services, linkage to medical care and prevention services, community-based HIV testing, social marketing and public-private partnerships in support of testing initiatives.

However, CDC must have the resources to expand the number of jurisdictions implementing routine testing in clinical settings – all jurisdictions have a need for increased resources for testing if we are to truly commit to providing access to testing for all individuals who do not yet know their HIV status. Those states and cities that are given the funding to increase HIV and AIDS case finding will also be advantaged in future years by increases in their Ryan White funding. CDC has an obligation to create a level playing field, particularly when future federal funding is at stake. CDC must also acknowledge the time and effort it takes to implement new HIV prevention programs. In particular, health departments must be given support as they develop their capacity and infrastructure to ensure the scale up of programs is successful and sustainable over time.

While we support an appropriate expansion of early diagnosis efforts in all forms, we must remind the nation that these services can never supplant a full expansion of interventions and services that have the potential to prevent new infections. Moreover, since HIV testing efforts

are largely a diagnostic endeavor, financing must be appropriately portioned out to all possible payers, most notably the public and private insurance systems in America.

Link People with HIV/AIDS to Care, Treatment and Prevention Services

Individuals living with HIV/AIDS are essential partners in the fight against this disease. Individuals who know their HIV status are more likely to reduce risk-taking behaviors and are therefore, less likely to transmit HIV to others. As importantly, once individuals are aware of their HIV-positive status, they can be linked to life-saving care and treatment services. An individual diagnosed early in their disease process and receiving quality care and treatment utilizes far fewer health care resources and has significant increases in quality adjusted life years. In addition to their improved health status, individuals adhering to a treatment regimen lower the probability they will transmit the virus to others, particularly utilizing ever-improving anti-retroviral regimens. The nation must make certain that these services are available to every American living with HIV/AIDS regardless of the status of his or her health care coverage. Systems like Medicare and Medicaid, the AIDS Drug Assistance Program, as well as all other parts of the Ryan White Program, particularly those that support primary care services, must be funded accordingly and have appropriate policies in place to ensure access to care and treatment.

Also important is the identification, notification and counseling of partners of persons living with HIV/AIDS. CDC, in partnership with health departments, has revised guidelines for the delivery of partner services. To extend the reach of this important core public health service, the revised guidelines integrate strategies that address both STD and HIV. With this intentional focus on both health concerns, human and fiscal resources can be better leveraged and the impact of prevention efforts can be maximized. In Maryland, increased efforts to educate public providers about Partner Services has led to 10-15 percent increase in acceptance rates for patients referred from these public testing sites. HIV/STD collaboration is also significantly enhancing our ability to monitor co-morbidity between HIV and other STDs, increase real-time identification of changes in geographic disease patterns, and provide key information for more effectively focusing prevention efforts.

Work to Eliminate Disparities Based on Race, Ethnicity, Gender, Sexual Identity and Class

HIV/AIDS prevention efforts must acknowledge and strive to eliminate the disparities that exist between those with power and privilege in our society and those who are marginalized. Further, HIV prevention efforts must be aligned to meet the needs of those who bear the greatest HIV/AIDS burden in the U.S. in order to provide the coverage of services necessary to reduce behaviors associated with HIV and other disease transmission, particularly STD and viral hepatitis.

The new incidence data show that in 2006, gay and bisexual men accounted for 53 percent of all new HIV infections. Infection rates among blacks were seven times greater than whites and nearly three times higher than Hispanics, a group that also was disproportionately affected. The HIV incidence rate for black females was 14.7 times the rate for white females, and the rate for Hispanic females was 3.8 times the rate for white females. The new estimates also underscore America's pervasive indifference toward ending racism, homophobia, poverty and sexism. Apathy about these root causes of health disparities continues to impede efforts to meet the needs of those most at risk for being infected with HIV/AIDS.

Confronting oppression and stigma must be at the foundation of the strategy to end the HIV/AIDS epidemic in America. Prevention efforts must be allowed to be delivered in a manner that respects the real life experiences of gay and bisexual men and African Americans, all who unacceptably bear the greatest burden of HIV disease. Woefully inadequate funding, oppression, and stigma have created the perfect storm in which thousands of gay and bisexual men and African Americans pay the ultimate price.

In an attempt to address some of the overlapping inequities of class, race, gender, and sexuality, state and local health departments have prioritized HIV prevention strategies targeting gay men. As an extension of the Florida Department of Health, the Office of HIV/AIDS of the Miami-Dade County Health Department (MDCHD) recently developed a participatory social marketing and community mobilization effort targeted at gay men (both HIV-positive and HIV-negative) aimed at instigating resistance against HIV/AIDS-related stigma in relation to underlying social inequality, namely, homophobia. The Anti-Homophobia campaign includes outdoor and print media to raise questions about social inequality, stimulate public discourse about HIV/AIDS-related stigma, and trigger action among gay men living with HIV/AIDS in Miami-Dade County. MDCHD began its social marketing efforts by erecting a makeshift graffiti wall in a high-visibility gay neighborhood in the Miami-Dade area and inviting residents to write responses to a question/statement posted on the wall. The graffiti wall remained for approximately four days, serving as a spontaneous community forum about HIV/AIDS-related stigma. Responses to the question, as well as observed reactions to the wall, were recorded by project volunteers and core group members on a daily basis and added to the data the core group used to develop their messages. This is one example illustrating health departments' commitment to addressing the real life issues faced by gay and bisexual men.

Address the Complexity of Individuals' Lives

The nation's HIV prevention response must operationalize programming that recognizes other real-life issues facing those being infected with HIV such as other STD, viral hepatitis, tuberculosis, reproductive health issues, homelessness and unstable housing, substance use/abuse and mental health concerns. Health departments are leading the way in efforts to integrate services at the client-level but need increased flexibility to scale up these efforts. Areas of service integration being implemented in health departments include HIV testing in venues offering STD and viral hepatitis services, screening and treatment of STDs and viral hepatitis in HIV venues, and the provision of hepatitis A and B vaccine for adults. Integration of services cannot be truly realized without a commitment to deconstruct the barriers of competing prevention and treatment philosophies, of "siloed" funding patterns, and of restrictive funding and federal application guidance and without additional resources given the limited federal dollars appropriated for these infectious diseases. To be effective in reducing new HIV infections, as well as STD and viral hepatitis infections, we must be able to easily leverage all necessary resources and services to offer a holistic response to the individuals we serve.

The U.S. has the unfortunate distinction of having the highest rates of STDs of all industrialized nations. In 2006 for the second consecutive year, the U.S. experienced record increases of the three leading STDs – chlamydia (5.6 percent), gonorrhea (5.5 percent), and syphilis (13.8 percent). After years of decline, our nation's urban areas continue to experience a significant

upswing in the number of syphilis cases, particularly among gay men and other MSM. A person with a pre-existing STD has a three to five fold greater risk of acquiring HIV/AIDS. Unfortunately, STD prevention programs at CDC have been cut or flat-funded since FY2003 while the number of persons infected continues to climb. State and local health departments need additional resources to integrate STD and HIV prevention programs, particularly targeting populations at highest risk for syphilis and other STD.

Approximately 6.25 million Americans are infected with the hepatitis C virus (HCV) and hepatitis B virus (HBV). Chronic viral hepatitis is now one of the leading killers of Americans living with HIV/AIDS. In addition, chronic viral hepatitis is the leading cause of liver cancer, now among the top 10 killers of Americans over the age of 25 years. Overall, the rate for HCV-related deaths in the U.S. is expected to triple by 2019. There is no federal funding to provide core public health services for viral hepatitis. Funds are needed for hepatitis B and C counseling, testing, and medical referral. States receive on average $90,000 for adult hepatitis prevention. This provides for little more than a position in the health department. Availability of testing is essential so individuals can take steps to protect their health and prevent infecting others.

The greatest remaining challenge for hepatitis A and B prevention is the vaccination of high-risk adults. High-risk adults account for more than 75 percent of all new cases of hepatitis B infection each year and annually result in an estimated $658 million in medical costs and lost wages. In FY2007, CDC allowed states to use $20 million of 317 Vaccine funds to vaccinate high risk adults for hepatitis B. States are integrating vaccination into service programs for persons with risk factors for infection (e.g., STD clinics, HIV counseling, and testing and referral sites, correctional facilities and drug treatment facilities). By targeting high-risk adults, including those with hepatitis C for vaccination, the gap between children and adults who have not benefited from routine childhood immunization programs can be bridged.

Use Structural-level Iinterventions

To truly change the course of the epidemic in America, structural-level impediments must be removed and structural-level assets must be leveraged. We must do everything in our power to promote policies that prevent new infections and promote health such as access to sterile injection equipment, buprenorphine and naloxone for people who use injection drugs; access to accurate science-based information for youth; and those that eliminate stigma and discrimination. We must also engage systems and institutions, including state and local governments, the Internet and faith communities, to leverage their support for our HIV prevention efforts.

A specific example is education for school-aged youth, who are desperately in need of HIV prevention services. The only federal funding for comprehensive sexual education currently available in the U.S. is through CDC's Division of Adolescent and School Health (DASH) program which provides funding to state and local education agencies to support the development and implementation of effective HIV prevention programs for school-aged children. The programs are locally designed to target those most vulnerable for sexual–risk taking behaviors. Comprehensive sexuality education programs have been found effective in delaying the onset of sexual intercourse, reducing the number of sexual partners, and increasing contraception and condom use. In FY2008, DASH's school health program was funded at $40.2 million.

In contrast, our nation has spent over $1 billion in the last five years to support abstinence-only-until marriage programs, which even government research has proven to be ineffective. Abstinence-only-until marriage programs are also stigmatizing for young people because they often reinforce heterosexual identities to the exclusion of gay, lesbian and transgender youth. Funding for DASH programs must be increased at the same time that Congress dedicates federal funding and support to broader comprehensive sexuality education programs. NASTAD supports Representative Barbara Lee's legislation, "The Responsible Education About Life Act," which would provide funding to all states to establish medically accurate and age-appropriate comprehensive sexuality education programs that includes information on both abstinence and contraception, from both a values and public health perspective.

Continuously Educate the Public

By sustaining public attention on HIV/AIDS and its impact, we can reinforce accurate, evidence-based information and begin to reduce the stigma associated with the disease. Educating the public about the economic, social and health consequences HIV/AIDS is having on our society will help build a supportive foundation for individual behavioral change and change at the community level. We must invest in a sustained national media presence that brings accurate knowledge and information about HIV to all individuals and communities in our country.

The Maryland AIDS Administration and the National Alliance of State and Territorial AIDS Directors thanks the Chairman, Ranking Member and members of the Committee for their thoughtful consideration of our recommendations to increase access to HIV prevention interventions provided by state and local health departments in response to data on each state's unique epidemic. Our response to the HIV epidemic in the United States defines us as a society, as public health agencies, and as individuals living in this country. There is no time to waste in our nation's fight against the HIV/AIDS epidemic.

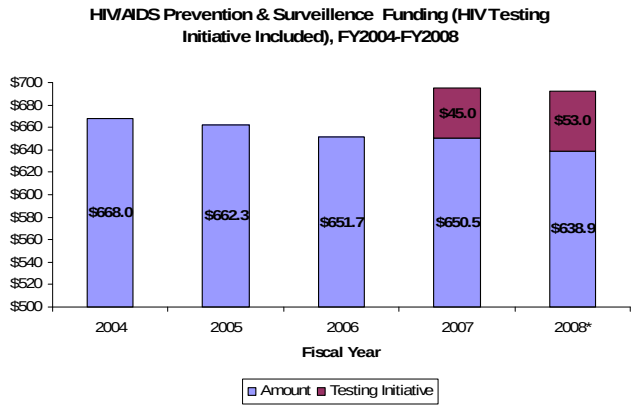
Support FY2009 HIV Prevention Funding

The Centers for Disease Control and Prevention (CDC) is on the verge or releasing revised estimates of HIV incidence that will show that there have been more new infections each year than previously thought. Funding has not kept pace and has in fact been cut since FY2003.

UNMET PROGRAMMATIC AND FISCAL NEEDS

Invest $608 million more or a total of $1.3 billion in core HIV prevention

The nation's prevention efforts must match our commitment to the care and treatment of infected individuals. State and local public health departments know what to do to prevent new infections, they just need the resources. The overall CDC HIV prevention and surveillance budget, measured by the Biomedical Research and Development Price Index used by the National Institutes of Health, has lost 11.4 percent of its purchasing power since FY2004.[1]



* The final amount for the HIV Testing Initiative in FY2008 is yet to be determined. $53 million is the amount included in the FY2008 Omnibus Report Language. The HIV Testing Initiative provides funding to 18 states and 5 cities.

State and local HIV prevention cooperative agreements have been cut by $28 million between FY2003 and FY2008 (this includes an estimated rescission amount for FY2008). With additional resources, the CDC can:

- Address the devastating impact on racial and ethnic minority communities.
- Expand outreach and HIV testing efforts targeting high-risk populations including racial and ethnic minority communities, young gay men of color, substance users, women and youth.
- Provide funds to state and local health departments to shore up their comprehensive prevention programs. Testing alone can never end the epidemic. All tools in the prevention arsenal must be supported.
- Build capacity and provide technical assistance to enable community-based organizations and health care providers to implement evidence-based behavior change interventions, ensure fiscal responsibility and refer partners of HIV-positive individuals to counseling and testing services.

HIV/AIDS PREVENTION & SURVEILLANCE

(Dollars in millions)

FY 2009 NASTAD Recommendation*:	**$1,300.0**
FY 2009 President's Budget:	**$691.1**
FY 2008 Appropriation:	**$691.9**

***an increase of $608.1 million.**

Invest $35 million more in HIV/AIDS surveillance

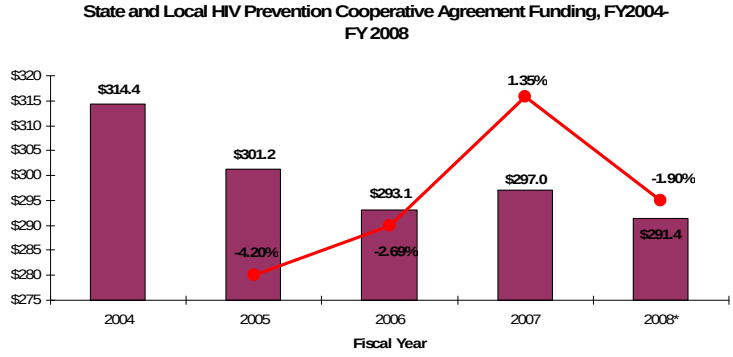
Core HIV/AIDS surveillance funding has eroded over the last decade, while the importance of this data has become paramount for targeting prevention efforts and directing Ryan White care and treatment resources. HIV/AIDS surveillance activities are critical in order to monitor the HIV/AIDS epidemic and to provide data for targeting the delivery of HIV prevention, care, and treatment services.

Maintain CDC's $45 million HIV Testing Initiative targeting communities of color

In FY2007, CDC awarded $35 million to 18 states and 5 cities to support routine testing in clinical settings particularly targeted to settings that see a large number of African Americans. The additional $10 million was used for activities to support the adoption of routine testing in clinical settings.

Block Funding of Duplicative Early Diagnosis Grant Program

No federal funds should be used to carry out the Early Diagnosis Grant Program in Section 209 of the *Ryan White Treatment Modernization Act of 2006.* This provision is a carve out of scarce HIV prevention resources when there is already $10 million dedicated to perinatal prevention and $45 million solely for routinization of HIV testing.



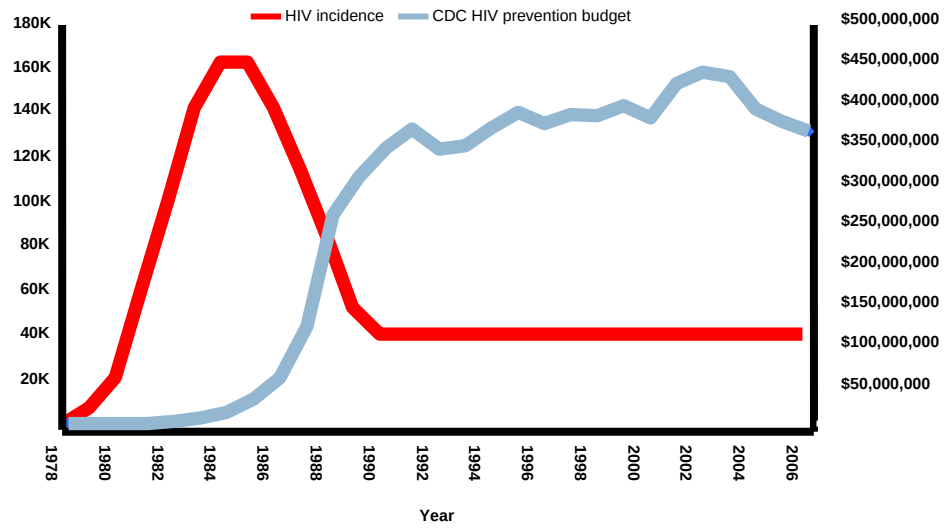
* This value includes an estimated rescission amount for FY2008

FY2009 HIV Prevention Funding Needs

The Need for HIV/AIDS Prevention Services

- The Centers for Disease Control and Prevention (CDC) estimates that over one million people are living with HIV disease in the U.S. and, of those individuals, approximately 436,639 are living with AIDS.[2]
- Despite declines in HIV infection rates among men who have sex with men (MSM) since the early years of the epidemic, MSM continue to be at risk for infection, accounting for an estimated 67 percent of HIV/AIDS diagnoses in 2006.[2]
- Although racial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic, the devastation of AIDS in communities of color continues to grow.
- An estimated 25,541 AIDS cases were diagnosed in communities of color, representing 71 percent of AIDS cases diagnosed as of 2006.[2]
- Of all AIDS cases diagnosed in 2006, 49 percent were African American, 19 percent were Hispanic, 1 percent were Asian/Pacific Islander, and less than 1 percent were American Indian/Alaska Native.[2]
- Although African Americans represent 13 percent of the population, the rate of diagnosis was ten times that of White Americans.
- Of the estimated 126,964 HIV cases for female adults and adolescents reported to CDC through December 2005, 79 percent of those cases were among African American and Hispanic women (64 percent and 15 percent respectively).[3,4]
- HIV disease was the third leading cause of death for black females ages 25-34 in 2004.[5]

Estimated Annual HIV Incidence and CDC's HIV Prevention Budget (In 1993 Dollars), 1978-2006



Source: Holtgrave, DR. Untitled. 2006. Retrieved March 18, 2008, from www.kaisernetwork.org/health_cast/uploaded_files/David_Holtgrave.pdf

References

[1] National Institutes of Health, Biomedical Research and Development Price Index, available on web at: http://officeofbudget.od.nih.gov/UI/GeneralBudgetInfo.htm.

[2] Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 2006*. Vol. 18. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/.

[3] CDC. *HIV/AIDS Surveillance Report, 2005*. Vol. 17. Rev ed. Atlanta: US Department of Health and Human Services, CDC: 2007:1–46.

[4] Includes HIV data from 33 states with confidential, name-based HIV reporting.

[5] WISQARS Leading causes of death reports, 1999–2004. Available at: http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html.

CDC HIV Prevention Funding
For State and Local Health Departments

Grantee	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
Alabama	$1,975,223	$2,311,365	$2,370,955	$2,357,253	$2,357,293	$2,307,088	$2,268,498	$2,129,587
Alaska	$1,337,005	$1,431,418	$1,482,135	$1,482,135	$1,473,391	$1,461,162	$1,417,619	$1,417,619
American Samoa	$101,231	$119,591	$184,591	$184,591	$137,627	$179,793	$174,435	$174,435
Arizona	$2,848,912	$3,209,754	$3,270,316	$3,270,316	$3,315,125	$3,287,746	$2,882,626	$3,028,369
Arkansas	$1,590,504	$1,801,670	$1,856,701	$1,856,701	$1,845,747	$1,646,284	$1,775,880	$1,582,922
California	$13,742,527	$15,662,315	$15,885,459	$15,853,584	$14,185,829	$14,036,477	$ 12,398,868	$13,618,189
Chicago	$5,760,017	$7,702,445	$5,784,509*	$5,761,293	$5,862,264	$ 5,625,957	$5,238,352	$5,443,889
Colorado	$4,205,236	$4,530,560	$4,589,810	$4,589,810	$4,562,729	$4,524,858	$4,390,017	$4,387,622
Connecticut	$5,885,439	$6,477,370	$6,546,470	$6,546,470	$6,507,845	$6,006,914	$6,516,225	$6,260,601
DC	$5,483,803	$6,107,404	$6,177,675	$6,099,142	$6,142,137	$6,093,037	$5,476,221	$5,736,854
Delaware	$1,754,129	$1,930,046	$1,983,775	$1,983,775	$1,993,035	$1,966,097	$1,897,423	$1,888,920
Fed of Micronesia	$88,635	$104,710	$224,710	$224,710	$189,486	$219,404	$212,866	$212,866
Florida	$17,892,945	$21,016,382	$21,178,983	$19,734,925	$19,996,914	$19,946,116	$19,254,142	$19,255,996
Georgia	$7,445,836	$8,432,934	$8,516,636	$8,516,636	$8,466,388	$4,544,989	$8,145,913	$8,090,047
Guam	$289,291	$341,759	$541,759	$541,759	$391,112	$439,589	$499,622	$499,622
Hawaii	$1,921,205	$2,081,019	$2,134,152	$2,134,152	$2,121,561	$2,101,770	$2,013,192	$2,041,255
Houston	$4,640,594	$5,420,848	$5,496,907	$5,496,907	$5,464,476	$5,204,596	$5,216,946	$5,092,037
Idaho	$791,440	$885,764	$936,478	$936,478	$930,953	$841,400	$869,899	$883,103
Illinois	$3,991,476	$4,199,153	$4,254,055	$4,254,055	$4,228,955	$4,193,855	$3,935,679	$4,068,878
Indiana	$2,303,735	$2,604,903	$2,663,260	$2,663,260	$2,699,936	$2,346,768	$2,347,105	$2,508,313
Iowa	$1,544,421	$1,672,475	$1,724,435	$1,724,435	$1,714,261	$1,580,679	$1,649,275	$1,649,372
Kansas	$1,620,421	$1,780,235	$1,833,369	$1,833,369	$1,822,551	$1,562,561	$1,519,181	$1,617,269
Kentucky	$1,782,340	$2,001,318	$2,002,304	$1,999,344	$1,990,559	$1,891,010	$1,899,445	$1,921,570
Los Angeles	$14,279,098	$16,843,670	$14,945,015*	$14,945,015	$13,395,763	$13,284,578	$12,888,698	$12,888,698
Louisiana	$4,728,909	$5,285,213	$5,346,802	$5,046,302	$5,407,409	$5,282,440	$5,227,174	$5,227,602
Maine	$1,570,331	$1,684,606	$1,736,857	$1,729,876	$1,706,787	$1,686,016	$1,635,773	$1,613,073
Marshall Islands	$67,998	$80,330	$130,330	$130,330	$97,171	$126,281	$122,518	$122,518
Maryland	$11,205,130	$13,258,768	$11,533,916*	$11,533,916	$10,244,452	$10,159,422	$9,619,186	$9,737,986
Massachusetts	$8,469,505	$9,168,525	$9,241,583	$9,241,583	$9,362,396	$9,007,880	$8,447,772	$8,655,094
Michigan	$6,229,813	$6,694,576	$6,765,218	$6,743,243	$6,733,011	$6,595,176	$6,386,659	$6,386,659
Minnesota	$3,045,530	$3,260,900	$3,316,087	$3,316,087	$3,296,521	$3,198,491	$3,163,933	$3,171,739
Mississippi	$1,836,906	$2,085,558	$2,141,975	$2,141,975	$2,112,454	$2,111,664	$1,623,221	$1,835,920
Missouri	$3,398,695	$3,844,260	$3,907,953	$3,907,953	$3,884,896	$3,682,508	$3,577,358	$3,737,842
Montana	$1,184,841	$1,274,334	$1,324,870	$1,324,870	$1,366,688	$1,236,899	$1,265,837	$1,263,843
N. Mariana Isles	$143,033	$168,974	$293,974	$293,974	$247,680	$181,526	$279,058	$1,205,605
Nebraska	$1,176,313	$1,291,214	$1,342,688	$1,342,688	$1,347,415	$1,339,368	$1,284,241	$192,386
Nevada	$2,573,129	$2,825,182	$2,881,724	$2,881,724	$2,864,722	$2,576,233	$2,751,027	$2,756,285
New Hampshire	$1,517,195	$1,634,512	$1,686,076	$1,686,076	$1,676,128	$1,622,216	$1,200,395	$1,598,713
New Jersey	$12,441,358	$13,829,529	$13,928,051	$13,928,051	$13,916,582	$12,807,632	$13,295,444	$13,192,984
New Mexico	$2,168,651	$2,328,107	$2,381,228	$2,381,228	$2,367,178	$2,339,634	$2,277,575	$2,270,963
New York	$26,743,052	$27,710,646	$28,141,146	$28,056,936	$28,075,896	$27,527,924	$26,820,184	$26,785,716

New York City	$18,264,748	$22,393,514	$22,207,921	$22,173,421	$22,291,440	$22,154,912	$21,267,893	$21,281,593
North Carolina	$3,866,927	$4,332,890	$4,397,336	$4,204,370	$4,497,416	$4,723,876	$4,338,589	$4,208,066
North Dakota	$598,468	$677,404	$727,549	$727,549	$723,256	$717,253	$695,879	$672,678
Ohio	$5,226,206	$5,701,970	$5,769,412	$5,722,537	$5,742,062	$5,352,428	$5,190,425	$5,206,904
Oklahoma	$2,285,536	$2,490,349	$2,545,146	$2,545,146	$2,530,130	$2,414,849	$2,138,838	$2,437,949
Oregon	$2,842,204	$3,098,818	$3,155,529	$3,155,529	$3,136,911	$3,110,875	$3,018,171	$3,018,171
Palau	$176,611	$208,641	$248,641	$248,641	$185,381	$242,937	$235,697	$235,697
Pennsylvania	$4,669,093	$4,969,099	$5,027,413	$5,027,413	$4,997,752	$4,956,271	$4,587,744	$4,377,928
Philadelphia	$5,664,367	$6,539,444	$6,613,822	$6,480,790	$6,575,584	$6,527,130	$6,328,212	$6,327,782
Puerto Rico	$3,496,948	$4,443,333	$4,434,870	$4,809,672	$4,332,551	$4,020,741	$3,897,634	$4,051,694
Rhode Island	$1,509,764	$1,663,940	$1,716,866	$1,716,866	$1,706,736	$1,692,570	$1,642,131	$1,642,131
San Francisco	$9,533,084	$10,426,780	$10,572,031	$10,572,031	$9,493,014	$9,440,710	$9,007,422	$9,005,739
South Carolina	$4,126,803	$4,597,329	$4,661,944	$4,654,369	$4,634,617	$4,591,174	$4,458,082	$4,460,943
South Dakota	$540,402	$621,307	$671,525	$671,525	$687,563	$658,962	$556,383	$642,291
Tennessee	$3,555,531	$4,026,504	$4,091,135	$4,091,135	$4,066,998	$4,033,242	$3,913,051	$3,913,051
Texas	$12,303,287	$13,858,060	$14,001,265	$13,932,861	$13,891,060	$13,765,747	$12,225,557	$12,936,907
Utah	$912,718	$1,069,758	$1,122,789	$1,122,789	$1,201,727	$1,189,912	$1,070,872	$1,071,870
Vermont	$1,385,458	$1,476,562	$1,527,157	$1,527,157	$1,518,147	$1,505,547	$1,460,681	$1,460,681
Virgin Islands	$580,494	$673,834	$633,512	$633,512	$472,964	$395,128	$454,452	$407,698
Virginia	$4,513,568	$5,100,755	$5,169,681	$5,156,853	$5,139,482	$4,654,553	$4,890,959	$4,938,495
Washington	$3,413,517	$3,845,483	$3,908,673	$3,908,673	$3,885,612	$3,853,361	$3,437,914	$3,337,579
West Virginia	$1,620,392	$1,709,980	$1,761,497	$1,761,497	$1,751,104	$1,739,675	$1,501,036	$1,684,759
Wisconsin	$3,287,978	$3,500,647	$3,798,017	$3,798,017	$2,940,691	$2,930,625	$2,790,680	$2,788,528
Wyoming	$691,119	$772,829	$823,077	$823,077	$818,221	$719,153	$784,765	$787,249
Total	**$286,841,075**	**$323,293,572**	**$322,271,745***	**$320,142,357****	**$313,723,742**	**$302,165,669**	**$293,758,549**	**$297,049,344**

**The decrease in FY2002 funding from FY2001 is due to the ending of the grants awarded for community coalition development projects to Maryland (Baltimore), Los Angeles and Chicago.*

***The decreases in FY2003 funding from FY2002 is due to some FY02 supplemental funding that was not built into base awards and because DSTD covered some of the direct assistance that had previously been covered by DHAP. Puerto Rico also includes the addition of unobligated funding."*